General Information

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Your Insurance Benefits: Help When You Need It Most

Your insurance, offered through the Employee Insurance Program, provides a financial safety net when you are ill or injured. Several health plans are available.

Through the **State Health Plan**, you may enroll in the Standard Plan, the Savings Plan or, if you are a retiree and eligible for Medicare, the Medicare Supplemental Plan.

Three **Health Maintenance Organizations** are offered:

- BlueChoice HealthPlan is available statewide.
- CIGNA is available in all counties **except** Abbeville, Aiken, Barnwell, Edgefield, Greenwood, Laurens, McCormick and Saluda.
- MUSC Options is available only in Berkeley, Charleston, Colleton and Dorchester counties.

For a list of retiree health insurance options, including the Medicare Supplemental Plan, refer to the Retirees/Disability Retirees chapter, which begins on page 161.

The **TRICARE Supplement** is available to those enrolled in TRICARE, the U.S. Department of Defense's health insurance program for the military. For eligibility requirements, see page 89.

Eligible employees also may enroll in the State Dental Plan and in Dental Plus. Dental Plus pays a higher amount for the same services covered by the State Dental Plan except orthodontia, which Dental Plus does not cover.

Active employees who enroll in a health plan receive Basic Life Insurance and Basic Long Term Disability Insurance at no charge.

ENROLLING IN A HEALTH OR DENTAL PLAN

Enrollment

If you are an eligible employee or retiree of a *participating group* in South Carolina, you can enroll in a health plan and the dental plan within 31 days of the date you are hired or the date you retire. A *participating group* is a state agency, public school district, county, municipality or other group that is authorized by statute to participate in, and is participating in, the state insurance plan.

To enroll in a health or dental plan, you complete the required forms, including a *Notice of Election (NOE)*. An *NOE* is the application used to: enroll in benefits; add or delete dependents; or change a subscriber's coverage level, beneficiary, name or address. Coverage is not automatic. You can also enroll your eligible dependents.

To enroll in Dental Plus, you must be enrolled in the State Dental Plan. You must cover the same family members under both plans.

After you enroll, please check your payroll stub to make sure the correct premiums are being deducted. Your health and dental coverage will continue from one year to the next as long as you are a full-time, permanent employee or an eligible retiree. Your coverage begins on the first day of the month if you are *actively at work* on the first working day of the month.

You are considered *actively at work* on your employer's scheduled workday if you are performing the regular duties of your occupation. You may be working at your usual work place or at another place, if you are required to travel. An employee is considered actively at work on a paid vacation day or on his employer's normal holidays only if he was actively at work on the last day before the vacation day or holiday.

If you are not actively at work on the first working day of the month, your coverage starts on the first day of the next month. Your enrolled dependents' coverage begins on the same day your coverage begins.

Every October, you may make changes in your **health coverage** without regard to special eligibility situations.

- During *annual enrollment,* eligible employees, retirees, survivors and COBRA subscribers may change health plans only. This includes changing to or from the TRICARE Supplement and to or from the Medicare Supplemental Plan.
- During *open enrollment*, which occurs in odd-numbered years, eligible subscribers may enroll in or drop their own health coverage and add or drop eligible dependents. You may also change your **dental coverage**.

Other changes you may make in your insurance coverage are explained in *The Insurance Advantage,* which you receive each September. Changes made during open or annual enrollment become effective the following January 1.

Your Right to Continue Health Insurance Coverage

The Health Insurance Portability and Accountability Act (HIPAA) established rules under which a worker can continue health insurance coverage when he changes jobs.

When you enroll in the plan, proof of *creditable coverage* from your previous insurance company may be used to reduce a *pre-existing condition* limitation, if there was no *significant break in coverage* (any break in coverage did not exceed 62 days).

Creditable coverage is prior coverage under a group health plan or insurance coverage or health benefits provided by state and federal statutes, as described or defined in HIPAA of 1996 and regulations. A creditable coverage letter that includes dates of coverage, names of all individuals covered and types of coverage must be presented to document creditable coverage. Please also state the reason for the loss of coverage.

A *pre-existing condition* is any medical condition, regardless of the cause of the condition, for which medical advice, diagnosis, care or treatment was recommended by or received from a licensed healthcare provider or practitioner in the six months preceding the covered person's enrollment date under the plan. Benefits for a pre-existing condition are payable only for treatment rendered 12 months after the enrollment date of a covered person, or 18 months after the enrollment date for a late entrant; provided, however, that creditable coverage without a break in coverage of greater than 62 days prior to the enrollment date is applied toward the waiting period for services related to a pre-existing condition to be payable. Pregnancy does not constitute a pre-existing condition.

For purposes of applying the pre-existing condition limitation, a *significant break in coverage* is a period of 63 consecutive days during which the individual does not have any creditable coverage, except that neither a waiting period, nor an affiliation period, is taken into account in determining a significant break in coverage.

Eligibility

An eligible active employee:

- Is employed by the state, a school district or a participating *local subdivision* and
- Works in a permanent, full-time position as defined in the plan and
- Receives compensation from the state, a school district or a participating local subdivision.

Retirement eligibility is explained in the Retirees/Disability Retirees chapter on page 163.

Eligible employees also include clerical and administrative employees of the S.C. General Assembly and judges in the state courts. S.C. General Assembly members and elected members of the councils of participating counties or municipalities, who also participate in the S.C. Retirement Systems (SCRS), are considered employees

for insurance purposes. Members of other governing boards are not eligible for coverage. If you work for more than one *participating group*, please contact your benefits administrator for further information. Permanent, part-time teachers may be eligible for state health, dental, Dental Plus, MoneyPlu$ and vision care benefits.

A *local subdivision* is any *participating group* other than a state agency or a public school district. Examples of local subdivisions include: counties, councils on aging, commissions on alcohol and other drug abuse, special purpose districts, community action agencies, disabilities and special needs boards, municipalities, recreation districts, hospital districts and councils of government. Since 1985, the General Assembly has passed legislation extending voluntary participation in the state insurance benefits program to certain local subdivisions. For a local subdivision to be eligible to participate in the state insurance benefits program, it must fall within one of the categories established by statute (Section 1-11-720 of the 1976 S.C. Code of Laws, as amended).

Transfers

As an active employee, you are considered a transfer if you change employment from one participating group to another with no more than a 15 calendar-day break in employment or in insurance coverage.

As an **academic employee**, you are considered a transfer if you complete a school term and move to another participating academic employer at the beginning of the next school term. Your insurance coverage must remain in effect during the summer. If you do not transfer to another participating academic employer, your coverage ends the last day of the month in which you were actively at work.

A transfer is not considered a new hire for insurance purposes. When you transfer, you must remain enrolled in all of the same insurance programs in which you were enrolled at your former employer.

When you leave your job, tell your current benefits administrator that you are transferring to another participating group. Check with your benefits administrator at your new employer to ensure that your existing benefits have been transferred.

Late Entrant

If you and/or your dependents do not enroll within 31 days of the date you begin employment, a special eligibility situation, or retirement, you cannot enroll yourself and/or your dependents until the next open enrollment period. Open enrollment is held in October of odd-numbered years, and your coverage takes effect the following January 1.

A late entrant is subject to the pre-existing condition exclusion limitation for 18 months after coverage begins. Proof of creditable coverage may be used to reduce a pre-existing limitation period, if any break in coverage did not exceed 62 days. A creditable coverage letter on company letterhead that includes dates of coverage, names of all individuals covered, types of coverage and reason for loss of coverage must be presented to document creditable coverage.

SPECIAL ELIGIBILITY SITUATIONS

A *special eligibility situation* is an event that allows eligible employees, to enroll themselves and/or their eligible dependents in a health and/or dental plan. Examples include marriage, birth, adoption or placement for adoption. Involuntary loss of other coverage is a special eligibility situation only for those who lost coverage. You have 31 days from the date of the event to complete an NOE requesting a change in coverage. A salary increase is not a special eligibility situation.

Changing Plans or Coverage

You can change to or from the Savings Plan, the Standard Plan, a health maintenance organization (HMO), the TRICARE Supplement or the Medicare Supplemental Plan only during October enrollment periods. There may be exceptions to this rule. Contact your benefits administrator for details if you are an active employee or if you

are a retiree, a survivor or COBRA subscriber of a local subdivision. Retirees, survivors and COBRA subscribers of other employers should contact EIP.

Retirees and survivors and their eligible dependents who are enrolled in a health plan may change to the Medicare Supplemental Plan within 31 days of Medicare eligibility or during annual or open enrollment.

If you are enrolled in Medicare, you may not enroll in the Savings Plan or the TRICARE Supplement. Active employees of any age and retired employees who are not eligible for Medicare can enroll in the Savings Plan.

You can change your dental coverage only within 31 days of a special eligibility situation or during open enrollment, which is in October of odd-numbered years.

You will find detailed information about each year's enrollment options in *The Insurance Advantage*, which you receive in September.

Marriage

If you, as a covered employee, wish to add a dependent spouse and/or child because you marry, you can do so by completing a Notice of Election (NOE) form within 31 days of the date of your marriage. Coverage becomes effective with the date of marriage. You cannot cover your spouse as a dependent if he is eligible, or becomes eligible, for coverage as an employee or as a retiree of a participating group. Exceptions may apply. If you do not add your spouse within 31 days of the date of marriage, you cannot add him until the next open enrollment period or within 31 days of a special eligibility situation.

Divorce

If you, as a covered employee, divorce, you must drop your spouse from your coverage by completing an NOE form within 31 days of the date the divorce decree is signed. Your divorced spouse's coverage ends the last day of the month in which the divorce decree is signed.

However, you may continue to provide health, dental and Dependent Life coverage for your former spouse and/or your eligible children who no longer live with you if the Family Court requires that you do so. A complete copy of the Family Court decree, along with an NOE, must be provided to your benefits administrator, who will send both to EIP. Retirees of state agencies, schools and institutions of higher education, survivors and COBRA subscribers should contact EIP. Retirees of local subdivisions should contact their benefits administrator.

You also can continue to cover your eligible dependent children if they live with you and you are financially responsible for them. A court order to cover a dependent child and/or ex-spouse does not create a special eligibility situation for the employee, if the employee is not already enrolled. In these cases, the employee will need to wait until the next open enrollment period or until a special eligibility situation occurs to enroll himself and the dependent child and/or ex-spouse.

If you remarry, you can cover your divorced spouse or your current spouse, but you cannot cover both under any EIP program. Dependents who lose coverage due to a qualifying event may be eligible to continue coverage under COBRA. For more information, you must contact your benefits administrator or EIP as soon as possible, but **no later than** within 60 days of the event or from when coverage would have been lost due to the event, whichever is later.

Adding Children

Eligible children may be added by completing an NOE **within 31 days** of the date of birth, gaining legal custody, adoption or placement for adoption. Children must be listed on your NOE to be covered, even if you already have family coverage. Notification to Medi-Call of the delivery of your baby does not add the baby to your health insurance. To add adopted children to your policy, you must also submit a court order or documentation from an authorized placement agency, along with any EIP-required forms. To verify custody, you must submit

a court order or an affidavit relinquishing custody to the subscriber, and also a form establishing custody. If you and your spouse are both covered employees, only one of you can cover your children.

Full-time Students

You may cover your dependent children, ages 19-24, who are full-time students. They must meet these requirements:

- Students must be enrolled in and attending an accredited high school, vocational/trade school or college/university **full-time**, as defined by the institution they attend.
- While summer school is not required for maintaining student status, dependents who enroll in summer school full-time may become eligible. However, they will lose eligibility if they do not re-enroll full-time the next semester/quarter.
- Enrollment in adult education night classes and correspondence courses is not considered full-time attendance.

If you are an active employee, EIP will send a Student Certification letter to your benefits administrator approximately 90 days before your dependent's 19th birthday. To continue coverage, this letter must be completed and returned to EIP within 31 days of the child's 19th birthday. You must also include a statement on letterhead from the educational institution he is attending that confirms that he is a full-time student and gives his dates of enrollment. Evidence of pre-registration is not adequate. If the child's 19th birthday occurs during the summer, return the Student Certification letter to EIP with the "Pending Student Certification" block marked. You must submit the letter from the institution by September 30 verifying that your child is a full-time student.

If your dependent, age 19-24, graduates from a community or technical college, a four-year college or a university and will return to school when the fall term begins, his insurance may be continued over the summer. To arrange this, you must provide EIP with a letter of acceptance from the school he will be attending. You must submit a Student Certification letter and statement on letterhead from the educational institution he is attending by September 30 that confirms that he is a full-time student and gives his dates of enrollment.

If your dependent, age 19-24, goes back to school full-time, you may again add him to your health coverage. To do so, within 31 days of eligibility, submit a Notice of Election (NOE) form and a statement on letterhead from the educational institution verifying that your dependent is a full-time student and giving his dates of enrollment. In this case, that would be the date he is again a full-time student.

If your 19-year-old is certified as a full-time student **while he is in high school,** you must notify your benefits administrator or EIP within 31 days of the date he leaves high school.

The TRICARE Supplement has its own requirements for coverage of dependents age 19 and older. Please refer to page 89 for more information.

When your child is covered as a full-time student, his eligibility for coverage ends the last day of the month in which he graduates, is no longer a full-time student, marries or the last day of the month in which he turns age 25, unless he is covered as an incapacitated dependent. It will be your responsibility to notify your benefits office that the child is no longer a full-time student and submit an NOE form dropping him from your coverage. If notification is received within 60 days of when coverage would have been lost due to the event, continuation of insurance under COBRA will be offered. Otherwise, it will not be offered.

EIP conducts periodic reviews of the eligibility of covered dependents ages 19-24. If your child is found to be ineligible, his coverage will be cancelled, and EIP may seek repayment of any benefits paid for him while he was ineligible.

If your child is **not** a full-time student, his eligibility for coverage ends the last day of the month in which he turns 19, unless he is covered as an incapacitated dependent. Your dependent child's eligibility for coverage also ends if he gets married.

Incapacitated Child

You can continue to cover your child, who is age 19 or older, if he is incapacitated and you are financially responsible for him. To cover your dependent child who is incapacitated, he must meet these requirements:

- The child must have been covered by health insurance continuously from the time of incapacitation.
- The child must be unmarried and must remain unmarried to continue eligibility.
- The child must be incapable of self-sustaining employment because of mental illness, retardation or physical disability and must remain principally dependent (more than 50 percent) on the covered employee, retiree, survivor or COBRA subscriber for support and maintenance.

Incapacitation must be established within 31 days of the child's 19th birthday or within 31 days of the date he is no longer covered as an eligible full-time student. The child must have been continuously covered by a health insurance plan from the time of incapacitation. An Incapacitated Child Certification Form must be completed by the subscriber and the child's physician and then sent to EIP for review. EIP may require additional medical documentation from the child's physician.

Gaining Other Coverage

If you or your dependents gain other group coverage, you have 31 days to change your coverage by completing an NOE and returning it to your benefits office with proof of the other coverage. To document that you have gained coverage, you must present a letter on company letterhead that includes dates of coverage, names of all individuals covered and types of coverage.

If you fail to make a coverage change within 31 days, you must wait until the next open enrollment period. For more details, contact your benefits administrator or EIP.

Involuntary Loss of Other Coverage

If you or your dependents are covered under another health or dental plan and you lose that coverage involuntarily because it was discontinued or the covered employee left his job, you have 31 days from the last day of coverage to enroll in coverage offered through the EIP. To enroll, you must complete an NOE and return it to your benefits office with proof that the insurance was discontinued. To document that you have lost coverage, you must present a creditable coverage letter or a letter on company letterhead that includes dates of coverage, names of all individuals who lost coverage, the types of coverage and the reason for the loss. Dependents must be listed on the NOE in order to be covered. Only family members who actually lost coverage may enroll. If you fail to enroll within the 31 days, you must wait to enroll until the next open enrollment, which occurs in October of odd-numbered years, or within 31 days of a special eligibility situation.

Leave Without Pay

If you are an active employee, you can continue your coverage for up to 12 months if you are on leave without pay, as long as you pay the required premiums. Leave must be approved by your employer. *(For information on Family and Medical Leave or military leave, contact your benefits administrator.)*

Medicare Before Age 65

If you or your covered dependent becomes eligible for Medicare before age 65 due to disability or end-stage renal disease (ESRD), the Social Security Administration will notify you. **You must notify EIP within 31 days of Medicare eligibility.** When you notify EIP, please submit proof of your Medicare eligibility, such as a copy of your Medicare card.

If Medicare is your primary insurance, **you should enroll in Medicare Part B,** which helps cover doctors' services and outpatient hospital care. EIP will pay your claims as if you were signed up for Part B.

If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance, when EIP discovers you are eligible for Medicare, EIP:

- Will immediately begin paying benefits as if you were enrolled in Medicare
- May seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.

Medicare at 65

The Social Security Administration should notify you or your dependents of your Medicare eligibility approximately 90 days before you turn 65 or you become eligible due to a disability. If you are not notified, contact your local Social Security office. If you are already receiving Social Security benefits when you turn 65, Medicare Part A starts automatically, and do not turn down Part B. If you are not receiving Social Security, you should sign up for Medicare before your 65th birthday, even if you are not ready to retire.

You should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under the health insurance plan that you have through EIP.

IMPORTANT MEDICARE NOTE:

If you or one of your dependents become eligible for Medicare, you must notify EIP within 31 days of Medicare eligibility. **If you do not notify EIP of your Medicare eligibility, and EIP continues to pay benefits as if it were your primary insurance,** when EIP discovers you are eligible for Medicare, EIP will:

- **Immediately begin paying benefits as if you were enrolled in Medicare**
- **Seek reimbursement for overpaid claims back to the date you or your dependent(s) became eligible for Medicare.**

If You Are an Active Employee When You Turn 65

If you are actively working and/or covered under a state health plan for active employees when you turn 65, you may delay enrollment in Part B because your insurance as an active employee remains primary. However, if you are planning to retire within three months of age 65, you should contact Social Security to learn about your Medicare enrollment options. When you do retire, you should sign up for Part B within 31 days of retirement.

Medicare will then be your primary coverage, and you need Part A and Part B for full coverage. Do not turn down Medicare Part B coverage because EIP will begin paying benefits as if you were enrolled in Part B.

Most Medicare recipients covered by health insurance plans offered through EIP should not sign up for Medicare Part D, the prescription drug program. Your drug expenses will continue to be covered under your health insurance.

BENEFITS ID NUMBER

On January 1, 2007, the Employee Insurance Program began using a new Benefits ID Number (BIN) for each subscriber. This unique number replaces the Social Security Number (SSN) formerly used in e-mails and other written communication between EIP and you and your dependents. It is designed to make your personal information more secure.

When you contact EIP, you may give your SSN or your BIN, and the Customer Service staff will be able to assist you.

Your BIN will be used on your Dental Plus card, if you are enrolled. The third-party administrators, such as BlueCross BlueShield of South Carolina, BlueChoice HealthPlan and CIGNA, will use your BIN or another secure number.

WHEN YOUR COVERAGE ENDS

Your coverage will end:

- The last day of the month in which you were actively at work, unless you are transferring to another participating group
- The last day of the month you enter a class of employees not eligible for coverage (for example, your working hours are reduced from full-time to part-time)
- The day after your death
- The date the coverage ends for all employees or
- If you do not pay a required premium when it is due. (For example, if you are on leave without pay or on COBRA and are paying the full cost, you must make a monthly payment.)

Dependent coverage will end:

- The date your coverage ends
- The date dependent coverage is no longer offered or
- The last day of the month in which your dependent is eligible for coverage.

If your coverage or your dependent's coverage ends, you may be eligible for continuation of coverage as a retiree, as a survivor or under COBRA. If you are dropping a dependent from your coverage, you must complete an NOE within 31 days of the date the dependent is no longer eligible for coverage.

COBRA

COBRA is short for the Consolidated Omnibus Budget Reconciliation Act. It requires that continuation of group health and/or dental insurance coverage be offered to you and/or your covered dependents if you are no longer eligible for coverage due to a qualifying event. Qualifying events include:

- The covered employee's working hours are reduced from full-time to part-time
- The covered employee voluntarily quits work, retires, is laid off or is fired (unless the firing is due to gross misconduct)
- The covered employee is separated or divorced from his spouse
- A covered child no longer qualifies as a dependent
- The covered employee or the parent of an eligible dependent child becomes eligible for Medicare.

To extend coverage under COBRA, the subscriber must notify his benefits office within 60 days of the qualifying event or the date coverage would have been lost due to the qualifying event, whichever is later. Otherwise, the individual will lose his rights to COBRA coverage.

To begin coverage under COBRA, a COBRA Notice of Election and premiums must be submitted. The premiums must be paid within 45 days from the date coverage was elected. Your first premium payment must include premiums for the month following the date you lost coverage, the month your elected coverage and the first full month of COBRA coverage.

For example: You lost coverage on June 30 and then elected coverage on August 15. You would be required to pay three premiums: one for the month following the date you lost coverage; one for the month in which you elected coverage; and one for the first full month after you elected coverage.

If you are enrolled in the TRICARE Supplement, continuation of health coverage is offered through Humana Military Healthcare Services, Inc. Please call 800-444-5445 for information. Dental coverage can be covered under EIP's COBRA plan if timely notification is made.

COBRA coverage becomes effective when the first premium is paid and remains in effect only as long as the premiums are kept up-to-date. If you need more information about COBRA, contact your benefits office or EIP.

Conversion: When COBRA Benefits Run Out

The Health Insurance Portability and Accountability Act of 1996 (HIPAA) guarantees that persons, who have exhausted COBRA benefits and are not eligible for coverage under another group health plan, have access to health insurance coverage without being subject to a pre-existing condition exclusion period. However, certain conditions must be met. In South Carolina, the South Carolina Health Insurance Pool provides this guarantee of health insurance coverage. For information, call 800-868-2500, ext. 42757, or 803-788-0500, ext. 42757, in Columbia.

Death of an Employee or a Retiree

If an active employee or a retiree of a local subdivision dies, a family member should contact the deceased's employer to report the death, to discontinue the employee's health and dental coverage and start survivor coverage for any covered dependents. If a state agency or school district retiree dies, a family member should contact EIP.

Survivors

Spouses or children who are covered as dependents under the State Health Plan or an HMO are classified as "survivors," upon the death of the covered employee or funded retiree. As survivors, covered dependents are eligible for a one-year waiver of health insurance premiums.

Participating local subdivisions may elect to, but are not required to, waive the premiums of survivors of retirees, but a survivor may continue coverage, at the full rate, for as long as he is eligible. Retirees of a participating local subdivision should check with their benefits administrator to see whether the waiver would apply.

After the first year, a survivor must pay the full premium to continue coverage. If you and your spouse are both covered employees or retirees at the time of death, your surviving spouse is not eligible for the premium waiver.

If you are a covered spouse or dependent child of a covered employee who was killed in the line of duty while working for a participating group, your premium will be waived for the first year after the employee's death. You must submit verification of death in the line of duty. After the one-year waiver, you may continue coverage, *at the employer-funded rate*, as long as you are eligible. Participating local subdivisions may elect to, but are not required to, contribute to your insurance coverage, but you may continue coverage, at the full rate, for as long as you are eligible.

State Dental Plan and Dental Plus premiums are not waived. However, survivors can continue dental coverage by paying the full premium.

As a surviving spouse, you can continue coverage until you remarry. If you are a dependent child, you can continue coverage until you are no longer eligible as a dependent. If you are no longer eligible for coverage as a survivor, you may be eligible to continue coverage under COBRA. Contact EIP for details.

Workers' Compensation

Insurance offered through EIP is not meant to replace Workers' Compensation and does not affect any requirement for coverage for Workers' Compensation insurance. It is not intended to provide or duplicate benefits for work-related injuries that are within the Workers' Compensation Act. If you need more information, please contact your benefits office or EIP.

Coordination of Benefits

Some families are eligible to enroll in two health plans. While the additional coverage may mean that more of your medical expenses are paid by insurance, you probably will pay premiums for both plans. Weigh the advantages and disadvantages carefully before you purchase extra coverage.

Most health plans have a system to determine how claims are handled when a person is covered under more than one insurance plan. This is called "coordination of benefits" (COB). When a subscriber has coverage under more than one plan, he can file a claim for reimbursement from each plan. Third-party administrators, such as BlueCross BlueShield of South Carolina or your HMO, coordinate benefits so that you get the maximum reimbursement allowed. That amount will never be more than 100 percent of your covered medical, dental or prescription drug expenses.

There are rules that determine the order in which the plans pay benefits. The plan that pays first is the *primary* plan. The *secondary* plan pays after the primary plan. Here are some examples of how that works:

- The plan that covers a person as an employee is primary to the plan that covers the person as a dependent.
- When both parents cover a dependent child, the plan of the parent whose birthday comes earlier in the year is primary.
- If you are eligible for Medicare and are covered as an active employee, your State Health Plan or HMO coverage is primary over Medicare. Exceptions may apply in the case of Medicare coverage due to kidney disease. Contact your local Social Security office for details.

For more information about how coordination of benefits works, see the appropriate sections.

PREVENTION PARTNERS

Prevention Partners, a unit of the Employee Insurance Program, is designed to help you and your family lead healthier lives. Its activities, programs and services promote good health through disease prevention, early detection of disease and chronic disease education.

A major initiative of Prevention Partners is the Preventive Worksite Screening. This comprehensive health screening measures cholesterol levels, blood pressure, triglyceride levels, kidney function and red and white blood cell counts. These measurements indicate if an employee is at risk for developing hypertension, diabetes and anemia.

This benefit is available for $15 to active and retired employees whose primary insurance coverage is the Standard Plan, the Savings Plan, BlueChoice HealthPlan, CIGNA HMO or MUSC Options.

The cost of the Preventive Worksite Screening does not contribute toward your annual deductible or out-of-pocket maximum.

Chronic Disease Workshops, another major program, give subscribers and their dependents information they need to help them take better care of themselves. Workshops include: Caregivers, Diabetes, Heath Disease, Asthma, Kidney Evaluation, Women's Reproductive Health, Weight Management, Medications, Men's Health, Cholesterol/Lipids and Gastrointestinal Ailments.

In 2002, the Budget and Control Board's Office of Research and Statistics compared 196 State Health Plan subscribers who attended a Diabetes Management Workshop between 1995 and 1999 with a group of subscribers who did not. During a two-year period, the medical and drug claims of the group that attended the workshop were $2,123.99 per person less than those who did not. The study indicates participants in the workshop were doing a better job controlling the risks of complications of their disease.

Other Prevention Partners programs include:

- Spring Wellness Walk
- Lifestyle change workshops on lowering risk factors, weight loss and exercise
- Worksite program consultation
- Volunteer Worksite Prevention Partners coordinator network and conferences
- Prevention Partners training workshops
- Preventive Worksite Immunization (influenza).

For more information on Prevention Partners, contact your benefits office, your Prevention Partners coordinator or call 803-737-3820 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area). You also can go to the EIP Web site at www.eip.sc.gov. Then click on "Prevention Partners," which is on the left side of your screen.

THE VISION CARE PROGRAM

This program offers you discounted vision care services. Participating ophthalmologists and optometrists throughout the state have agreed to charge no more than $60[1] for a routine, comprehensive eye examination. If you are fitted for contact lenses, you may pay more because that can require additional services. Participating providers, who include opticians, have agreed to give a 20-percent[1] discount on all eyewear except disposable contact lenses.

[1]*These amounts can change yearly. Contact your benefits office, provider or EIP for the current amounts.*

If you are covered by more than one vision care program, you can have the discounts offered under this program or through your other coverage, but not both.

The eye examination should include at least these tests and services:

- Complete eye and medical history review
- Visual acuity far and near, with and without glasses
- Tonometry
- Screening visual fields
- Refraction
- External motility, biomicroscopic and dilated
- Ophthalmoscopic examinations
- Initiation of diagnostic and treatment programs as necessary, including prescription of lenses, medication and other therapy, arranging for special diagnostics or treatment services, consultations, laboratory procedures or radiological services as may be indicated.

Treatment must be within the scope of the license of the provider. Consult your eye care provider for details on any of these services.

You may participate in this program if you are a full-time or part-time employee, retiree, survivor or COBRA participant. Your dependents also are eligible. You do not have to be enrolled in the State Health Plan or a health maintenance organization. It is your responsibility to show your provider some type of employment-related identification to prove you are eligible for the Vision Care Program. If you do not, you may not receive the discount.

Providers Are Available Statewide

To see the list of participating providers, go to the Employee Insurance Program's Web page, www.eip.sc.gov. Click on "Choose Your Category" and then select your category (Active Subscribers, Retirees etc.). Next, choose "Online Directories" and then select "Vision Care." You can search for providers by county or by state. **This is the most up-to-date list.**

If your provider is not listed, you may wish to ask if he gives discounts through the state's Vision Care Program. If your provider would like to be part of the program, he should call the Employee Insurance Program. Although EIP lists providers who participate in the program, the state does not recommend any specific eye care provider.

If you do not have access to the Internet, ask your benefits administrator to print a copy of the list for you. You can also request one by writing to EIP at P.O. Box 11661, Columbia, SC 29211, or by calling 803-734-0678 (Greater Columbia area) or 888-260-9430 (toll-free outside the Columbia area).

No Claims to File

The Vision Care Program is a discount program. You do not file claims and will not receive reimbursement for routine eye examinations or eyewear, including contacts. If you have a MoneyPlu$ Medical Spending Account, you can file a reimbursement claim with MoneyPlu$ for your vision care expenses.

If you have questions about this program, please contact your benefits office or EIP.

EIP ON THE INTERNET: EASY ACCESS TO YOUR INSURANCE INFORMATION

Like many organizations, the Employee Insurance Program offers helpful information through the Internet. Two places to find it are *EIP Direct* and the EIP Web site.

EIP Direct is a bimonthly newsletter sent to your benefits administrator, who may send you the information or the newsletter itself. The newsletter gives you information about changes in benefits, answers questions about benefits and tells you about programs that may be of interest to you, such as Prevention Partners chronic disease workshops. Copies are available on the EIP Web site, www.eip.sc.gov. Choose "News & Updates" and then "Newsletters."

The Web site is also the place to find other ideas about how to make the best use of your insurance, as well as links to the Web sites of EIP's third-party administrators. When you go to www.eip.sc.gov, you will see a bar across the top of the home page. It has several tabs, including:

- FAQ (general information, as well as questions about the Savings Plan and HSAs)
- News and Updates (includes a tab that takes you to "Newsletters," such as *EIP Direct* and *Avenues*)
- Links (direct access to companies that administer EIP programs).

When you select "Choose Your Category," which is on the left, you will see a list of the types of subscribers served by EIP. Most of you are "Active Subscribers," or employees. When you click on your category, you will receive a list of choices. They include "Eligibility," "Forms," "On-line Directories" (lists of providers that are part of the health plan networks), and "Rates." Click on "Publications" to see a list that includes this benefits guide. You can use the "binoculars" search feature to help you find specific topics in the guide.

"Prevention Partners" is one of the choices listed on the left side of our home page. Click on it for ways to improve your health. Under "Early Detection," for example, you will find a list of the regional Worksite Screenings.

"Insurance Managers" provides direct links to the Web sites of the third-party administrators. These sites give you access to your account information, including claim status, verification of authorization for inpatient and outpatient visits and Explanations of Benefits.

If you need assistance or, additional information or would like to make a suggestion, click on "Need Customer Service?" to send EIP an e-mail.